Ruptured Mycotic Aortic Aneurysm Secondary to Escherichia Coli Bacteremia in an HIV-Positive Patient

Keywords: Aortic aneurysms; Epidemiology; Escherichia coli

Introduction

HIV-related vasculopathy comprises a broad spectrum of disease, including occlusive disease, aneurysm formation, and microangiopathy [1,2]. HIV-related aneurysmal disease has been shown to be a distinct pathologic entity from atherosclerotic and mycotic aneurysms [3] and can be distinguished by several features—the presence of multiple aneurysms in atypical locations, younger patient age, fewer traditional atherosclerotic risk factors, and unique histopathology defined by peri-adventitial inflammatory infiltrates [4-8]. It remains unclear to what extent direct viral action versus opportunistic bacterial infection is responsible [2]. Mycotic aortic aneurysms (MAA) are also a rare and highly morbidity subset of abdominal aortic aneurysms (AAA), comprising only 0.7% to 1.8% of all AAA [4,5]. Management of MAA has been a challenging problem for the vascular surgeon, as it often presents late in the course of disease in immunocompromised hosts and carries a high risk of progression to rupture, fulminant sepsis, and death [4,5]. MAA traditionally mandates operative intervention in the form of in situ graft placement or extra-anatomic bypass followed by aortic debridement and ligation, though successful endovascular management has recently been described for non-ruptured MAA [6,7]. Commonly implicated organisms include Staphylococcus and Salmonella species, with Escherichia coli less frequently identified [4,8]. In the HIV-infected population, MAA secondary to opportunistic pathogens have also been reported [9,10], and this report focuses on an unusual case of rapidly progressive, ruptured MAA in an HIV-positive patient successfully managed with in situ prosthetic reconstruction.

Case Report

A 71 year-old male with past medical history significant for hypertension, HIV, benign prostatic hypertrophy, and tobacco abuse presented to a community hospital complaining of several weeks of escalating back pain. The patient's HIV has been well-controlled on HAART therapy with Genvoya (Elvitegravir, Cobicistat, Emticitabine, Tenofovir Alafenamide), with recent CD4 count of 524/mm³ and an optimal surgical treatment of mycotic aortic aneurysms.

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Upon the patient's arrival, impulse control was initiated with nicardipine and Esmolol infusions, with goal heart rate <70 beats per minute and goal systolic blood pressure <130 mmHg. His white blood
cell count was within normal limits at this time. He was taken emergently to the operating room for open repair through a midline laparotomy. The supraceliac aorta was exposed for emergency control as needed and the infrarenal aorta was approached near the bifurcation. Dense periarterial inflammation was encountered which had distorted the ureteral anatomy and was accompanied by caseating granulomatous changes in the nearby lymph nodes. The left and right common iliac segments were cleared for clamp placement and following careful mobilization of the left ureter and duodenum, the inferior mesenteric artery was controlled. Moving proximally, it was clear that the densely inflamed and adherent left renal vein could not be salvaged. Additional dissection established space for clamp placement below the bilateral renal arteries, and following systemic heparinization, the infrarenal aorta was clamped. The aortotomy was extended from the bifurcation cranially through the left renal vein and this ligation was buttressed with nearby inflammatory tissue. Patent lumbar arteries were oversewn and the aortic wall was resected as able. More specifically, the region of rupture was debrided, including evacuation of retroperitoneal thrombus, and the cavity was thoroughly irrigated with antibiotic solution. Tissue culture was sent from this region. An interposition graft was then performed using a rifampin-soaked 14 mm × 7 mm Hemashield bifurcated graft (Maquet, Rastatt, Germany). Given the healthy appearance of the tissue at the bifurcation, the limbs were trimmed, effectively creating a tube graft. The proximal and distal anastomoses were created using 3-0 prolene sutures in circumferential running fashion, and an omental flap was created and fastened into place over the graft with running 2-0 vicryl suture. Given patent hypogastric arteries bilaterally and the presence of brisk back-bleeding from the inferior mesenteric artery, it was not re-implanted. The abdomen was irrigated with antibiotic solution and closed.

The patient's post-operative course was complicated by acute kidney injury secondary to contrast nephropathy, but this returned to baseline by post-operative day 4 and the remainder of his recovery was uneventful. HAART therapy was maintained throughout his hospitalization and an emphasis was placed on post-operative nutrition. Intra-operative tissue culture was positive for pan-sensitive E. coli, and the patient was maintained on a six-week course of IV ceftriaxone with plans for long-term oral suppression therapy per the infectious disease specialists. He was discharged to a rehabilitation facility on post-operative day ten.

Discussion

Mycotic aneurysms may affect any artery, with the aorta, peripheral arteries, cerebral vessels, and visceral arteries affected in descending order of frequency [11,12]. Mycotic aortic aneurysms (MAA) comprise only a small minority of aortic aneurysms [4,5] and have been associated with an aggressive course with rapid progression. A large contemporary series of MAA have reported a high frequency of rupture at the time of presentation, ranging from 38% to 85% [4,6,8] with in-hospital mortality of suspicion is critical to ensure timely diagnosis and prompt surgical intervention. Aortic aneurysms typically occur as a viral-induced angiopathy but bacterial infection may also contribute to the infectious complications or need for reoperation [7]. However, in cases of MAA with rupture at the time of presentation, most authors continue to recommend open surgical management [6]. As the vascular surgeon's armamentarium expands, thoughtful consideration of individual patient factors will be critical to improving outcomes and providing the best care possible.

Conclusion

Aortic aneurysm formation in HIV-infected patients may be due to a viral-induced angiopathy but bacterial infection may also contribute in the immunocompromised host. Mycotic aortic aneurysms typically have an aggressive and highly morbid course; therefore a high index of suspicion is critical to ensure timely diagnosis and prompt surgical intervention.

References


